Final Report of Stakeholder Work Group Recommendations

Michigan Health Insurance Exchange Planning

June 17, 2011

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INTRODUCTION

When the state sought proposals to carry out a Health Insurance Exchange planning process, its RFP included a requirement that public input be obtained through a work group process. The RFP directed the formation of five work groups and broadly laid out the issues that should be considered by each group. The work groups are:

- Governance
- Finance, Reporting, and Evaluation
- Technology
- Business Operations
- Regulatory and Policy Action

With this guidance as a foundation, a work group process that invited a broad array of health care stakeholders to consider specific questions regarding the design and operation of an Exchange was developed and carried out. The work groups served the critical purpose of providing stakeholder input on key decisions the state must make related to the design and operation of an Exchange. The work groups were advisory in nature; the process was designed to give the state a sense of where consensus exists and opinions diverge on key issues, not to arrive at final decisions regarding the implementation of an Exchange.

WORK GROUP MEMBER RECRUITMENT AND SELECTION

In early January 2011, a diverse set of people and organizations whose expertise and knowledge aligned with that needed for the work groups was identified. Those individuals and groups represented the following health care stakeholders:

- Business/employers
- Consumers
- Health plans
- Health professionals
- Hospitals
- Insurance brokers/agents
- Labor
- Local government
- Long-term care
- Mental health
- Non-hospital safety-net providers
- Pharmaceutical manufacturers
- Public health
- Research/university

- Vendors/information technology
- Other

An email was sent on January 25 to a list of health care stakeholders, organizations and associations representing the sectors listed above. The email invited recipients to attend a kick-off meeting where they could learn more about the planning process and the work groups. In addition to an invitation to the kick-off meeting, the email messages included a link to an online form where individuals could indicate their interest in participating in the work group process. Potential work group members used the form to provide their contact information, identify which sector they represent, indicate their top three work group choices, and provide a brief statement of their experience and expertise.

The kick-off meeting, which was held on February 1, was attended by 146 people. Approximately 220 people ultimately expressed interest in participating in a work group. To ensure that discussions were meaningful and manageable, work groups were limited to 30 members each. Broad stakeholder membership in each work group was ensured. In addition to the 30 voting members, the state identified four to five staff to serve as non-voting subject matter experts on each work group. Finally, legislative staff members were invited to attend each of the work group meetings as non-voting members.

WORK GROUP CHARTERS AND TASKS

Prior to work group member recruitment and selection, charters were developed for each work group to lay out meeting schedules, expected outcomes, tasks and deadlines, desired member expertise, the role of the facilitator, and any overlap of tasks that existed among the five work groups. The charters were included with the initial invitation to indicate interest in work group participation so that potential members could identify where their interests and expertise matched the needs of the work groups. The primary tasks for each work group are described below.

Governance

The Governance Work Group was charged with recommending whether Michigan should develop its own Exchange, partner with another state, or defer to the federal government. The work group was also tasked with recommending whether the state should develop separate or combined individual and small business exchanges.

The Governance Work Group held its first meeting on February 9, before any of the other work groups met so that these early recommendations could inform the recommendations that were made in the other four groups.

The work group was also responsible for recommending whether the Exchange should be a public, quasi-public, or private non-profit organization. Finally, the Governance Work Group was charged with proposing a structure and process for the governance and staffing on an Exchange for the state, including the composition of a governing board and general rules for transparency and procurement processes.

Finance, Reporting, and Evaluation

The Finance, Reporting, and Evaluation Work Group was charged with developing recommendations for evaluating the effectiveness of the Exchange and suggesting mechanisms for ensuring transparency with regard to the operation of the Exchange. The group was also tasked with making recommendations for the development of accounting and auditing standards for the Exchange, and recommending a strategy for financing the Exchange to ensure that it is operable by 2014 and self-sustaining by 2015.

Technology

The Technology Work Group was charged with providing recommendations for approaches that should be implemented to ensure that consumers are aware of and understand how to use the Exchange. The work group members also identified which current state systems should be interoperable with the Exchange and identified sources of additional data that may not be available through the systems identified for interoperability.

Business Operations

The Business Operations Work Group was tasked with providing several recommendations for the overall operation of the Exchange, including whether the Exchange should be the exclusive distribution channel for insurance in the individual and/or small group markets; an approach for qualifying health plans to sell insurance in the Exchange; methods to manage financial risk and avoid adverse selection within the Exchange; and how best to track and coordinate eligibility for Medicaid and federal tax credits and subsidies.

Regulatory and Policy Action

The Regulatory and Policy Action Work Group was ultimately charged with developing draft legislation to establish a health insurance exchange in Michigan. The group was also tasked with providing recommendations for companion legislation to support the goals of the exchange, including changes to Michigan statutes that conflict with the requirements of the ACA, if necessary.

Recommendations and the Voting Process

Facilitators had a shared process for facilitating discussions and working with members to develop recommendations. As work group members discussed the material presented ahead of and during meetings, recommendations on which the group would vote were formulated. Recommendations were posed to the group based on points made during discussion and votes were taken using green, red, and yellow cards, which members used to indicate their level of support for recommendations. A green card indicated a vote in favor of the recommendation, a yellow card indicated having reservations about the recommendation, and a red card indicated opposition to the recommendation.

Two-thirds of present voting members either in favor (green cards) or opposed (red cards) to a recommendation was considered consensus. When a large number of yellow cards were presented, additional discussion would be held to see if questions could be answered or concerns might be addressed through slight modifications to a recommendation. Occasionally a series of votes was held on a single idea as modifications were made in attempt to formulate a recommendation that two-thirds of the members could support. Meeting summaries include final recommendation language and comments in support of the recommendation, but also include minority perspectives to ensure that the state has a full sense of the discussion that led to a recommendation.

WORK GROUP DELIVERABLES

The work group process resulted in a set of recommendations from each work group and, in the case of the Regulatory and Policy Action Work Group, draft legislation for the establishment of an Exchange in Michigan. In all, more than 50 consensus-based recommendations were made. While some narrowly met the two-thirds threshold, many were unanimous or nearly unanimous. Documents detailing the consensus-based recommendations made in each work group were developed as final reports of the work groups' deliberations. The reports, which provide the rationale for each recommendation and briefly summarize any minority perspectives, are each included here.

Governance Work Group

Stakeholder Work Group Final Report with Recommendations

INTRODUCTION

The Governance Work Group met five times between February 9, 2011 and March 28, 2011 to discuss and ultimately offer recommendations on eight questions related to governance:

1. Should Michigan have a state-specific Exchange; partner with another state; or defer to the federal government?
2. Should Michigan have regional (subsidiary) Exchanges within the state?
3. If the state develops its own Exchange, should the Exchange be a completely public entity; a quasi-public entity; or a state-established private, non-profit entity?
4. Should the state develop two separate Exchanges—one for individuals and the other for small business—or a combined Exchange for both of these populations?
5. What should be the structure and composition of the Exchange's governing board?
6. What information about the operation of the Exchange, qualified health plans, and health insurance options is most important to share with the public?
7. How should Michigan's Exchange procure goods and services?
8. What hiring practices should be put in place?

Early on the Work Group decided that its efforts would be advanced if its members could agree on a set of desirable attributes for the Michigan Exchange. Work group members agreed that the Exchange should:

- be accountable to the public
- be transparent
- be consumer friendly
- make the shopping experience for health insurance as easy to navigate as possible
- be strong in its consumer protections
- be efficient in its administration
- be nimble and agile in its responses to the insurance market
- foster competition among qualified health plans
- reduce costs (or reduce the rate of cost increases)
- have excellent administration (quality of staff and processes)
- have staff who understand the health insurance market
- be well coordinated with Medicaid
- be independent of political influence

This consensus on attributes informed the work group's discussions on structure, board composition, and other issues it considered.

RECOMMENDATIONS

Recommendation #1:

Michigan should establish a state-specific exchange, as opposed to partnering with other states or deferring to the federal government.

Final Vote Tally

The vote was 25 members in favor and none opposed.

Rationale

The vote reflected a general belief that there were too many Michigan-specific issues and needs to make either of the other alternatives feasible. Aspects of Medicaid eligibility and preserving access to local Michigan HMOs were two prominently mentioned concerns. Work group members also believed that the federal government was poorly positioned to run the Exchange properly and working out acceptable agreements with other states—given differences in markets, laws, and regulations—would be difficult.

Minority Perspectives

No opposition to a state-specific Exchange was expressed. However, it was noted that there would be a good deal of work in the legislature to ensure that the resulting Exchange is well crafted and conforms to the provisions established in federal law.

Recommendation #2:

Michigan should establish a single Exchange for the state that is mindful of and attentive to regional differences and needs.

Final Vote Tally

Twenty-five participants endorsed the single Michigan Exchange approach. None supported having regional Exchanges.

Rationale

Work group participants believed that having multiple Exchanges within the state would multiply complexity and administrative costs without providing any real value. A properly defined and structured state Exchange could accommodate regional differences and offer links to regional resources.

Minority Perspectives

No opposition to having a single Michigan exchange was expressed. Several members noted, however, that the Exchange would have to deal with the fact that access to care varied greatly around the state, especially for persons with low incomes, and that resources for finding regular sources of care varied from region to region.

Recommendation # 3:

The Michigan Exchange should be an independent public authority at its inception, but should be allowed to seek non-profit status at a later date if doing so was deemed advisable by the executive director and governing board.

Vote Tally

Two related votes were taken, one on the recommendation that the Exchange be an independent public authority, and a second on the question of whether it should be allowed to seek non-profit status later.

- Seventeen members supported the proposal that the Exchange should be an independent public authority; seven members indicated having concerns with the proposal. None were opposed.
- Sixteen members supported the proposal to allow the Exchange to become a non-profit at a later date; four members indicated having concerns with the proposal. Four members were opposed.

Rationale

Many work group members saw the independent public authority and non-profit options as being part of a continuum, with differences more of degree than of kind. The independent public authority status was deemed best initially because its structure would best suit the Exchange's responsibility to accommodate both public and private interests. Non-profit status for the Exchange was also understood to have virtues, notably greater isolation from political pressures. Members believed that if, in the opinion of the executive director and board, the Exchange could better pursue its mission through non-profit status, it should be allowed to seek such status at a later date.

Minority Perspectives

Establishing the Exchange as an independent public authority was not controversial. There were, however, concerns expressed about the wisdom of allowing the Exchange to seek non-profit status. The main concern arose from the fact that many responsibilities of the Exchange will be public (administration of subsidies and tax credits, eligibility determination and enrollment in Medicaid). For that reason, seeking a greater isolation from the processes of government may not be advisable.

Recommendation # 4:

The state should have a single exchange for both individuals and small businesses and the same governance structure within the Exchange should oversee both individual and small business risk pools.

Vote Tally

To separate votes were taken. One dealt with whether there should be separate exchanges for individuals and small businesses. The second addressed the issue of whether there should be separate individual and small businesses governing boards operating under the umbrella of a single, unified Exchange.

- On the question of whether there should be a single, unified exchange for small businesses and individuals, 21 members voted in favor and two members indicating concerns. None opposed it.
- On the question of whether there should be a single governing board within a single administration, 21 work group members voted in support, and one member indicated concerns. One member was opposed and two members abstained.

Rationale

The same logic that led to the recommendation that there be a single state Exchange prevailed here. Administrative efficiency and avoiding the cost of separate entities and governing structures was the primary consideration of work group members, who also felt that a properly structured and administered board could handle the responsibility of fairly administering to both groups. Work group members also noted that there would be individuals who would seek both individual and small business coverage during the course of a year. A single organization that handled both would be best positioned to assist such individuals.

Minority Perspectives

No member believed that there should be completely separate organizations. It was, however, argued by some that there should be separate governance structures within a single organization because small business and individual insurance issues can vary significantly.

Combined Individual and Small Business Pools

It should be noted that the work group was unable to reach consensus on the question of whether the small business and individual risk pools should be combined or remain separate.

Those who supported keeping the pools separate tended to stress that there were different profiles in small business and individual pools, and that adverse selection would be more of a problem in the latter than in the former. Supporters of separate pools also argued that the individual and small business pools would be big enough on their own and that employers would almost certainly want to have their own group.

Supporters of a single pool felt that concerns about adverse selection were overstated because most people would comply with the law rather than paying the penalty and because of the influx of large numbers of healthy people into the insurance market. They believed that, in general, the larger the risk pool the better.

Recommendation #5:

There should be thirteen voting and one non-voting members on the Michigan Exchange governing board, representing

- health care consumers
- self-employed individuals
- small employers
- large employers
- labor
- health insurance industry
- health care providers
- health plan benefit specialist
- actuary
- health economist
- three ex officio, voting state government officials
- one ex officio, nonvoting state government official

The three state officials should include representatives from the Michigan Departments of Community Health (MDCH), Human Services (MDHS), and Technology, Management and Budget (MDTMB). The Insurance Commissioner should also be on the board, but in a non-voting capacity.

Vote Tally

The work group voted first on the adoption of the model laid out in legislation in Connecticut—after consideration of models from several states—and second on the nature of state representation.

- Eighteen members of the work group voted to recommend that Michigan's Exchange governing board be identical to the Connecticut model; four members voted in opposition.
- Seventeen members of the work group voted to recommend that the Michigan's Exchange governing board have a non-voting insurance commissioner but voting representatives from

MDCH, MDHS, and MDTMB; three members indicated having concerns with the proposal. Three members voted in opposition to the proposal.

Rationale

This board composition was adopted with the explicit proviso that it was assumed that the Exchange would be a market organizer, not a purchaser of insurance products (please see the Business Operations work group report for further discussion of this issue). In general, work group members endorsed this proposal because it adequately balances a number of competing interests and concerns. It provides for independent expertise but also recognizes that considerable expertise can be provided by groups that are affected by Exchange decisions and activities. It recognizes that while state agencies do not run the Exchange they too have a considerable stake in seeing it function well. The Connecticut model was understood to include affected groups without being too large and unwieldy.

Minority Perspectives

Some participants believed that the office of the state Insurance Commissioner was an integrally involved and should be given voting rights. Others felt that a smaller, more management-oriented board without specifically "slotted membership" would be best because it averted the conflicts of interest that will arise among the stakeholders on the Connecticut model board.

Recommendation #6:

Appointments to the Exchange governing board should be made by the Governor. In making appointments, the Governor should be mindful of the need for diversity on the board.

Vote Tally

Because of the discussion, two votes were taken. The first dealt with gubernatorial appointment, the second dealt with State Senate advice and consent. A separate, related vote was taken on the diversity question.

- Fifteen members of the work group supported giving the Governor the power to appoint members to the governing board; three members indicated having concerns with the idea. Three members were opposed.
- On the issue of whether the recommendation should have Senate advice and consent provisions, eight group members supported the idea; ten indicated concerns. Three members opposed giving the State Senate these powers.
- Twenty-three members supported a proposal urging that diversity be considered in making appointments. No member opposed the proposal.

Rationale

There was general agreement among members that one of the important responsibilities of any governor is to make appointments to statewide boards. The Governor is the only official elected statewide for the purpose of making these kinds of decisions and has the best perspective on what kinds of interests need to be balanced and considered. Others felt that the introduction of an advice and consent provision was potentially problematic because it might embroil the Exchange in politics and make timely appointments to the board difficult.

Minority Perspectives

Some members noted that there was ample precedent for the Insurance Commissioner and MDCH director making these sorts of appointments.

Recommendation # 7:

The Exchange governing board should have the responsibility for hiring an executive director to run its day-to-day operations.

Vote Tally

Twenty-one members of the Work Group supported the idea that hiring an executive director is a key governing board responsibility.

Rationale

Hiring executive directors is one of the responsibilities of governing boards everywhere. It is what they do.

Minority Perspectives

None.

Recommendation #8:

The Exchange should be subject to the state Open Meetings Act (OMA), including the standard exceptions that allow for non-public executive sessions in specified instances.

Vote Tally

Twenty-three members supported the proposal that the Exchange board be subject to OMA. None were opposed.

Rationale

There was a general acceptance of the view that since the Exchange would be conducting important public business its meetings ought to be open to the public.

Minority Perspectives

None.

Recommendation #9:

The Exchange should be subject to the requirements of the Michigan Freedom of Information Act (FOIA).

Vote Tally

Nineteen members supported the recommendation that the Exchange be subject to FOIA; four members indicated having concerns with the proposal. None were opposed.

Rationale

There was a general acceptance of the view that since the Exchange would be conducting important public business, the information upon which it based its decisions was public.

Minority Perspectives

There was some concern that, given the Exchange's status as an independent public authority, it might be hard to enforce timely compliance with FOIA requests.

Recommendation #10:

All board member conflicts of interest would be declared, and the full governing board would formally distinguish between general and direct conflicts. In the case of a general conflict, it would be acceptable for members to vote. In the case of a direct conflict, it would not. The Executive Director and Board should have the discretion to more fully flesh out the policy.

Vote Tally

Twenty one members supported the proposal that conflicts be open and declared and that board members recuse themselves in the case of direct conflicts. One member opposed the proposal.

Rationale

The conflict of interest policy recommended here comports with the "slotted" board composition outlined in recommendation # 5 (above). The work group accepts the fact that general conflicts are unavoidable given the composition of the board—that is, every board member will have a potential financial interest—but views this as acceptable if the board is balanced and members with direct conflicts (i.e. those involving specific personal or organization self-interest) recuse themselves when they arise. The recommendation gives interest groups a voice, and seeks to take advantage of their expertise, without allowing any one group undue influence.

Minority Perspectives

It was noted that the mere fact of being "in the room" might confer an unfair advantage to members or the organizations they represent—whether they recuse themselves or not.

Recommendation #11:

Michigan should not alter the requirements of federal law that defines a small employer as one having between 1 and 100 employees.

Vote Tally

Twenty-three members agreed to the proposal. None were opposed.

Rationale

As is the case in many states, Michigan's law currently defines a small employer as one having between two and 50 employees. Federal laws allow states to keep the lower definition from the time health reform takes effect in 2014 until 2016. By 2016, all states would have to amend their laws to define a small employer as having between one and 100 employees. Work group members felt it would be least disruptive and most productive now to begin the process of amending state law to conform to the expanded federal definition.

Minority Perspectives

No opposition was expressed, though it was noted that the effort would require legislative approval.

Recommendation #12:

The Exchange governing board should formally adopt a procurement policy that is flexible, transparent to the public, consistent with state law, and reflects a commitment to diversity.

Vote Tally

All twenty-three members present voted to adopt the proposed recommendation.

Rationale

It is expected that the Exchange, as an independent public authority, will be something of a hybrid organization with state and private funding, state and private employees, and state and private governance. It seems likely that if state funding is used for Exchange purchases, state procurement rules would come into play. In instances where only private funds were involved, the Exchange would have a good deal more flexibility. In addition, large procurements might best go through the state's competitive bidding process. The recommendation allows for the dual nature of the new Exchange while also insisting that a commitment to transparency in purchasing and diversity of vendors is good public policy.

Minority Perspectives

None.

Recommendation #13:

The new governing board should examine viable hiring models in existing public authorities and develop a policy based upon best practices and the goals of the Exchange, including flexibility, transparency, and diversity.

Vote Tally

All twenty-three members of the work group present voted to adopt the recommendation. None were opposed.

Rationale

The Exchange will have public and private clients and it will likely need both private sector and state agency employees to allow it to function effectively. If state agency employees are used, hiring practices may have to conform to state civil service requirements. Hiring from the private sector might be less restricted. The work group believes that the Exchange governing board should examine existing independent authority hiring practices with a view to developing a policy appropriate to its mission and needs. Any policy of this sort should reflect widely accepted values of transparency and diversity.

Minority Perspectives

None.

Business Operations Work Group

Stakeholder Work Group Final Report with Recommendations

INTRODUCTION

The Business Operations Work Group met on four occasions between February 11, 2011 and March 28, 2011. The work group charter called for recommendations on a variety of disparate topics and for input into deliberations of each of the other work groups. Specifically, the Business Operations work group was charged to:

1. Recommend whether the Exchange should be the exclusive distribution channel for small group and for individual insurance
2. Recommend an approach for the certification of qualified health plans.
3. Identify options for addressing the risk of adverse selection in an Exchange, including on-going risk monitoring, risk adjustment tools, and data sources.
4. Identify key staff roles and develop a proposed organizational chart for operation of an Exchange
5. Review and provide comment on the technology gap analysis conducted by the Technology work group, regarding the capacity and adaptability of existing state systems, and tracking and coordinating newly eligible individuals efficiently, accurately and with transparency.
6. Provide the Finance, Reporting, and Evaluation work group with suggestions for ensuring the sustainability of an Exchange after 2014.

RECOMMENDATIONS

Recommendation #1:

Michigan should not establish Michigan's Exchange as the exclusive distributor of *individual* market health coverage in Michigan.

Final Vote Tally

18 work group members voted against making the Exchange the exclusive distributor of individual coverage; 6 members voted in favor of making Michigan's Exchange the exclusive distributor of individual health coverage; and 2 members were unsure.

Rationale

The work group identified several reasons to allow an *individual* insurance market to continue to operate outside of an Exchange.

- Dual markets would assure a viable option if the Exchange market falters or fails.
- Restricting the market to an Exchange would likely reduce the variety of consumer plan options.
- Funneling all individual policies to an Exchange in 2014 will add complexity to the state's implementation of health reform's many requirements.
- Dual markets allow the state to reduce the outside market in the future, if desired. However, if the outside market is eliminated, it would be difficult to re-create.
- Some consumers may not like or trust the Exchange and may prefer the outside market.

Minority Perspective

Some members asserted that a single distribution channel would likely be simpler to administer and easier for consumers to use, may reduce the cost of individual coverage, and would vest all carriers in the success of the Exchange. Some also asserted that having too many plan choices is likely to confuse consumers and mask the relative value of plan variations.

Recommendation #2:

Michigan should not establish its Health Insurance Exchange as the exclusive distributor of *small group* market coverage.

Final Vote Tally

19 work group members voted against making the Exchange the exclusive distributor of small group coverage; two work group members voted in favor of establishing Michigan's Exchange as the exclusive distributor of small group coverage.

Rationale

The reasons for allowing a *small-group* insurance market to continue to operate outside of an Exchange were similar to those offered by work group members for maintaining a separate *individual* market. They made the following additional observations related to small group markets:

- Business needs more plan options to differentiate itself as a prospective employer.
- Small businesses have verbalized that they are "not interested" in purchasing coverage through an Exchange.
- Small business uses producers to select plans and to provide other employee benefit-related services, which may not be available through an Exchange.

Minority Perspective

Those work group members in favor of making the Exchange the exclusive distributor of small group coverage made the same assertions that were made in favor of having the Exchange be the exclusive distributor of individual coverage.

Recommendation #3:

Michigan's Exchange should impose no additional restrictions (outside of those currently required of insurers in Michigan and required in the ACA) on carriers and plans wishing to participate in the Exchange.

Vote Tally

19 work group members voted in favor, five work group members voted no, and three work group members were not certain.

Rationale

Work group members identified the following potential advantages to having limited or no restrictions for plan participation in an Exchange:

- Equal access to Exchange consumers and the ability for carriers to operate under a single set of rules governing provision of coverage to individuals and small businesses.
- Low administrative cost associated with providing Exchange coverage.
- Greater access to Exchange business for new carriers and smaller carriers.

- Greater opportunity for innovative plan designs.
- Reduced political, regulatory influence from Exchange staff or advocates on plan design.
- Consistency between the Exchange and non-Exchange individual and small group markets.
- An increase in the number of available plan options and increased flexibility to consumers in finding an appropriate plan.
- Carriers may see lower compliance costs to meet Exchange requirements; carriers would also avoid costs associated with applying for Exchange participation.
- More available plans may make it more likely for small business to participate in Exchange, because employers use insurance offerings to differentiate themselves from competitors and recruit employees.
- Producers would have more options to present to both individual and small business clients, especially those with access to subsidies or tax credits.
- This model is easiest to implement and cheapest to operate for an Exchange.

Minority Perspectives

Those who expressed concern about this recommendation noted the following:

- If the number of plans on the Exchange is not restricted, it may be difficult for consumers (especially those with little insurance purchasing experience) to effectively compare available plans.
- A broader array of insurance plans increases complexity for health care providers (doctors, clinics, hospitals), who must deal with multiple formularies, benefits, etc. Consumers may rely upon health care providers for assistance in choosing a health plan, which makes the delivery system less efficient.

Recommendation #4:

If Michigan's Exchange functions as a distribution channel and imposes no restrictions on Exchange participation for carriers, it should have the flexibility to impose some limits on the number of plans offered to consumers.

Vote Tally

22 members voted in favor of this recommendation and four work group members voted against this recommendation.

Rationale

A very high number of plans in each "precious metal tier" would make it difficult for consumers to make meaningful comparisons between plans. The Exchange should have the authority to restrict the number of plans offered through the Exchange in cases where the sheer volume of available plans makes the Exchange useless to consumers.

Possible Risk Adjustment Strategies within Michigan's Exchange

Work group members reviewed potential adverse selection threats associated with the general structure of a Health Insurance Exchange. The work group explored several options for mitigation of risk to an Exchange (in addition to those provided for in the ACA). The work group discussed these options in detail and voted on whether they should be recommended to the State. The work group did not reach consensus on any of the proposals listed here:

A. Michigan should require carriers that sell outside the Exchange to sell on the Exchange.

B. Michigan should require carriers that sell on an Exchange to sell plans in all of the precious metal tiers.
C. Michigan should require all carriers selling in Michigan to sell plans in all of the precious metal tiers outside of the Exchange.
D. Michigan should require all plans sold outside of an Exchange to meet the ACA requirements for Exchange plans, such as accreditation, customer satisfaction, etc.

Key Staff Roles and Proposed Exchange Organizational Chart

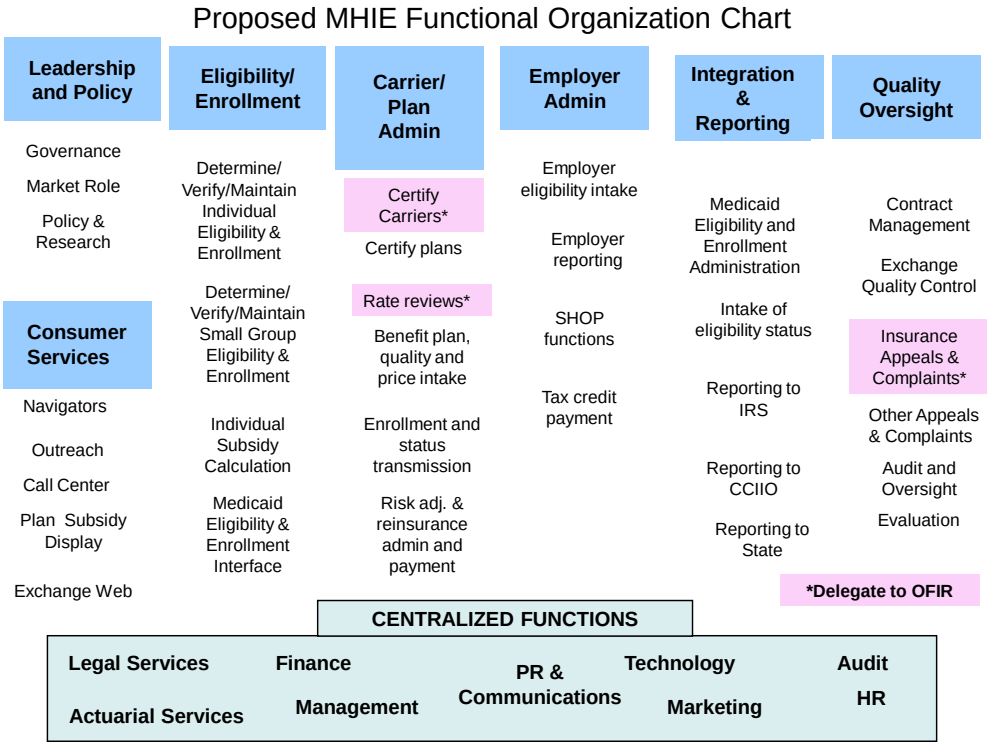
The work group recognized that the staffing needs of an Exchange could vary significantly based on many key decisions that have not been made, such as how active a Michigan Exchange will be in certifying plans. Accordingly, the group focused on the key functions of an Exchange and the principles that should govern the design of its organizational structure. The work group proposed the following principles:

- An Exchange should be structured to allow flexibility and modifications, especially during its first few years. A "walk before you run" approach should guide hiring and contracting.
- An Exchange should be organized to emphasize customer service.
- An Exchange should be designed around its functions rather than titles or positions.
- Formal titles and a bureaucratic structure is less desirable than a flatter, more flexible organization.
- Where efficiencies can be gained, an Exchange should contract for services and functions, especially in its first years.

With respect to specific "make versus buy" choices or opportunities to contract out for Exchange functions, the work group made the following suggestions and observations:

- Where actual or potential conflicts of interest exist, an Exchange should retain the function.
- An Exchange is obligated by the requirements of federal rules, Medicaid, IRS, and other legal obligations.
- Where interface with federal and state government and other key stakeholders are required, an Exchange should retain or strongly manage the function.
- In areas of political and/or public sensitivity, an Exchange should retain the function.
- Where technical expertise can be purchased and matters of scale are involved, functions should be contracted out.

The following diagram captures the key functions of an Exchange



Comment on Technology Gap Analysis

The Business Operations Work Group was asked to comment on the technology gap analysis prepared by the Technology Work Group, focusing on the capacity of current state-based systems to provide interoperability with the enrollment functions of an Exchange. Specifically, comments were sought about the MDCH Data Warehouse, Bridges, CHAMPS, MIEnrolls/MIChild, and Children's Special Health Care Services.

The following considerations about the use of these systems and interoperability within an Exchange were identified.

- Most of the current challenges associated with any of the named systems are due to business processes or human elements, not on the technology itself.
- Key business rules that must be part of an efficient Exchange include:
  - Clear definitions of who can overwrite data, for what reasons, when, and how overwrites/updates will be identified.
  - The definitive source for data elements must be understood and agreed upon by all parties entering and accessing data.
  - The data source and date must be identifiable for every data element.
- The Exchange must employ a master client identifier.
- Providers need access to real time eligibility and benefit information for all persons covered through the Exchange. This would improve the efficiency of patient care significantly.

It was also noted that most of the people who will be covered by the SHOP and many who will buy individual coverage through the Exchange are not likely to be in any of the data systems that were

studied. The systems discussed will primarily assist with determination of Medicaid or MIChild eligibility.

Comment on Financial Sustainability of an Exchange

The work group was charged to provide the Finance, Reporting, and Evaluation work group with suggestions for ensuring the sustainability of an Exchange after 2014. Placed hypothetically in the position of CEO of the Michigan Exchange, members were asked to identify considerations for ensuring the financial sustainability of the Exchange by 2014. Comments included:

- The Michigan Exchange will certainly be faced with a very large volume of enrollees in the individual market on January 1, 2014. Accordingly:
  - Smooth Exchange operations are essential at start-up to assure customer satisfaction and avoid bad press that would be toxic to the Exchange;
  - Start-up efforts must be aggressive and vigorous to assure that enrollees in the Exchange are covered on January 1, 2014. Thus, all business processes, technologies, marketing, and customer support must be ready to deploy on October 1, 2013; and
  - All systems will require extensive pre-market testing.
- Based on the above, the Exchange's costs will be quite high in the period up to 2014.
- Costs after 2014 should be significantly less, because they will be based on maintenance of operations.
- The Exchange must not encumber itself with inappropriate operating expenses for technology systems scaled to the start-up period. Careful budgeting in this area is paramount.
- Michigan should fully exploit the technical support and lessons learned from states with innovator grants and states that are ahead of Michigan in the process of implementing an Exchange.
- Michigan should seek support from foundations that can support learning communities and other replicability efforts among states in all areas of Exchange operation, but especially in budgeting and financing Exchanges.

Finance, Reporting, and Evaluation Work Group

Stakeholder Work Group Final Report with Recommendations

INTRODUCTION

The Finance, Reporting, and Evaluation Work Group met four times between February 24, 2011 and April 6, 2011 to discuss and ultimately offer recommendations on questions related to three topics: finance, reporting, and evaluation. The work group's recommendations in each topic area are presented below.

FINANCE RECOMMENDATIONS

Work group members were asked to address the following question: How should the Exchange be financed to ensure it is operable by 2014 and self-sustaining by 2015?

Work group members agreed that the cost of the Exchange should be spread broadly, financing strategies should maximize federal funding, and a mix of revenue strategies should be used to support the Exchange. Several work group members expressed the concern that the low income population not be burdened by Exchange costs passed on to the consumer. Since many of the revenue options result in the consumer paying, either directly or indirectly, transparency is critical in whatever financing options are recommended. The work group deliberated financing strategies for startup and ongoing operation of the Exchange separately. Recommendations 1 through 5 address startup financing. Recommendations 6 through 9 address financing strategies for ongoing operation of the Exchange.

Recommendation #1:

If Medicaid is included in the Exchange, state and federal Medicaid funds should be used to pay Medicaid's fair share of startup costs, including the cost of establishing a Medicaid eligibility determination system if that function is included in the Exchange.

Recommendation #2:

The state should seek the maximum amount of federal funds available to support startup costs of the Exchange.

Recommendation #3:

The state should seek funding from foundations, including private, community, and national foundations, to support startup costs of the Exchange.

Final Vote Tally

The work group unanimously supported the three recommendations above.

Rationale

The vote reflected the work group members' beliefs that there should be multiple financing strategies to support the startup of the Exchange and existing funding sources should be maximized.

Recommendation #4:

There should be a fee for carriers to participate in the Exchange beginning at startup. This funding mechanism should be only one piece of the financing strategy for startup of the Exchange. The assumption is that the carrier will cover the fee out of what they typically would spend for distribution outside of the Exchange. The balancing act for the Exchange is to determine how much the Exchange can charge carriers without setting the fee at a level where the carriers choose not to participate or the cost passed on to the consumer becomes a burden.

Final Vote Tally

Nineteen work group participants endorsed the recommendation; two expressed concern; one opposed it.

Rationale

Much of the rationale is included in the recommendation because work group members wanted to capture their assumptions and concerns. During deliberations, work group members noted that carriers have to provide the same plan at the same price inside and outside the Exchange, but their cost to provide it inside the Exchange should be lower because they won't incur the distribution cost that they do outside the Exchange. In effect, this difference in cost should be what they could pay the Exchange without an increase in their overall costs. The decision carriers will have to make is whether they can offer the plan at the same price on the Exchange, pay the participation fee, and still make enough profit as a result of increased volume and lower distribution costs to offset the cost to participate in the Exchange.

Minority Perspectives

Two work group members expressed concern that the details of this financing strategy are critical; it is not possible to know how carriers will respond until the amount of the fee and mechanisms for implementing it are known. They believe there is too much uncertainty about the total amount of administrative costs that will be imposed on carriers to know if there will be any real savings that can be shifted to cover a participation fee.

Recommendation #5:

Since all of Michigan benefits from the creation of the Exchange, state revenue options that spread the cost over the widest base possible by ability to pay should be one piece of the financing strategy at startup.

Final Vote Tally

Seventeen work group participants endorsed the recommendation; one expressed concern; two opposed it.

Rationale

Most work group members agreed that all citizens in Michigan will benefit from the creation of the Exchange. Improved access to affordable health insurance should result in higher coverage levels, reductions in uncompensated care, increased access to health care, and better health outcomes for individuals and the population as a whole. Therefore, they suggested the state should treat the startup of the Exchange as an investment for the people of Michigan.

Minority Perspectives

Some members disagreed with the assumption that all of Michigan benefits from the Exchange, suggesting that there could be winners and losers. They also opposed new taxes to support the Exchange. They suggested there should be enough money available from federal startup grants and Medicaid funding to support the startup of the Exchange.

Recommendation #6:

If Medicaid is included in the Exchange, the state should seek to maximize federal matching funds for Medicaid costs associated with the ongoing operation of the Exchange.

Final Vote Tally

Eighteen work group participants endorsed the recommendation; two expressed concern; none opposed it.

Rationale

The vote reflected the work group members' beliefs that existing funding sources should be maximized and Medicaid funding should pay for Exchange functions related to the Medicaid population.

Minority Perspectives

Some members expressed concern about the volatility of Medicaid revenue, particularly when that revenue begins to dwindle in 2016 or 2017. Others said there were too many unknowns regarding Medicaid involvement in the Exchange.

Recommendation #7:

Once the Exchange is operational, carriers should be required to pay a fee to participate in the Exchange. This funding mechanism should be one piece of the financing strategy for ongoing operation of the Exchange. During the operational phase of the Exchange, the Exchange will still be challenged to set the participation fee at a level that does not discourage carriers from participating and does not result in a cost burden for the consumer.

Final Vote Tally

Eighteen work group participants endorsed the recommendation; one expressed concern; one opposed it.

Rationale

As in their discussion of financing mechanisms to support startup costs, work group members noted that distribution costs should be lower for carriers operating within the Exchange. Therefore, carriers should be able to contribute some amount to support the ongoing operation of the Exchange without increasing their costs or the burden for consumers.

Minority Perspectives

Some members were concerned that the cost will continue to increase to the point that it becomes a disincentive and plans will not want to participate. Others said the success of this particular financing mechanism will depend on the volume of participation in the Exchange.

Recommendation #8:

After it is well established, the Exchange should seek entrepreneurial opportunities that are related to its mission and do not present conflicts of interest.

Final Vote Tally

Fifteen work group participants endorsed the recommendation; five expressed concern; none opposed it.

Rationale

Work group members said that the Exchange has to be creative and entrepreneurial in the long term. There may be many opportunities for value-added service, such as services that small business owners

need to provide a group insurance plan. Other entrepreneurial activities, such as advertising on the Exchange website, might also be considered. Work group members cautioned that the Exchange must first attend to the core functions of the Exchange.

Minority Perspectives

Some work group members said they have reservations about a quasi-governmental agency competing with the private sector in other service areas. Some said the potential exists that the capital expense necessary to manage the entrepreneurial activity will add to the cost of the Exchange.

Recommendation #9:

State revenue options that spread Exchange costs over the widest base possible by ability to pay should be one piece of the financing strategy to support the ongoing operation of the Exchange.

Final Vote Tally

Fifteen work group participants endorsed the recommendation; two expressed concern; three opposed it.

Rationale

Work group members said the state has something to gain from the ongoing operation of the Exchange and should consider support of the Exchange as an investment.

Minority Perspectives

Some work group members said if the Exchange is indeed successful, it should be able to sustain itself without raising taxes. Some added that using state revenue at startup may be acceptable because it is a short timeframe.

REPORTING RECOMMENDATIONS

Work group members were asked to address the following questions: What accounting and auditing standards should be put in place for the Exchange? What can be done to efficiently limit fraud and abuse? The work group grounded its discussion and recommendations on the Governance Work Group recommendation that the Exchange be an independent public authority.

Recommendation #1:

The Exchange should have an annual audit and follow Generally Accepted Accounting Principles, either those developed by the Financial Accounting Standards Board (FASB) or the Governmental Accounting Standards Board (GASB) as appropriate.

Recommendation #2:

Information on the overall financial dealings of the Exchange should be publicly available and posted on the Exchange website, including disclosure of any potential conflicts of interest and that part of any management letter pertaining to the financial dealings of the Exchange.

Recommendation #3:

The Exchange needs to develop robust internal control and reporting policies and procedures, taking into consideration best practices for risk management and assessment, key performance indicators on cost, oversight and publication of information on key subcontractors, and compliance with existing regulatory requirements at the state and federal level.

Recommendation #4:

Health plans participating in the Exchange should be required to comply with all accounting and auditing requirements established for health plans by the ACA or the State of Michigan, including requirements established by the Michigan OFIR Commissioner and MDCH requirements specific to Medicaid plans. The intent is that the Exchange should not call for requirements over and above what are already imposed.

Final Vote Tally

All work group participants endorsed the four recommendations above.

Rationale

The general position of the work group was that adherence to accounting principles and standards should be a given for the Exchange. They emphasized that transparency and availability of information are critical. Assuring transparency regarding the financial dealings of the Exchange is integral to protections against fraud and abuse. Transparency of financial information will also help control costs.

EVALUATION RECOMMENDATIONS

Work group members were asked to address the following questions: What information should be collected regarding the quality, performance, and cost of qualified health plans in the Exchange? How and with whom should the information be shared? How should enrollee satisfaction with plans and the Exchange be monitored and reported? What measures should be used to monitor overall performance of the Exchange?

The Finance, Reporting, and Evaluation Work Group identified several high-level principles regarding how and with whom information should be shared. Foremost among these was the emphasis on "keeping it simple and accurate." It should be intuitive. Consideration should be given to consumer literacy, including computer literacy. The group agreed that careful consideration should be given to the development of different levels of information in the presentation of consumer information. The group also suggested that there should be thorough beta-testing by consumers of the information provided, how it is provided, and how the Exchange functions for the consumer. Work group members noted that they may not be the best individuals to represent consumers who would actually be using the Exchange.

Recommendation #1:

In addition to the information that is required from participating health plans under the ACA, health plans participating in the Exchange in Michigan also should be required to provide the following information: exclusions from coverage; coverage, cost, and procedures for out-of-area care; availability of providers, including whether the provider is accepting new patients and the language(s) spoken by the provider; enrollment periods and any limitations or restrictions on enrollment and disenrollment; demographic characteristics that affect eligibility for the health plan; and participation of plan providers in health information exchanges.

Final Vote Tally

Twenty work group participants endorsed the recommendation; five expressed concern; none opposed it.

Rationale

Work group members believed that the ACA requirements for health plan transparency and disclosure were a good starting point, but additional information about health plan structure and processes will be important to consumers.

Minority Perspectives

Some work group members expressed concern that the information required should be kept simple initially, in the interest of keeping it easy to understand for the consumer and to keep Exchange costs down. Some work group members said, while provider use of electronic medical records and participation in health information exchanges is important, consumers would probably not make decisions about purchasing a health plan based on that information.

Recommendation #2:

Evaluation and ongoing monitoring are distinct, related activities that are both important to assess performance of the Exchange.

Final Vote Tally

All work group participants endorsed the recommendation.

Rationale

The work group recognized that there will be a need for data and information to use to monitor the development and ongoing operation of the Exchange. This information will be important for continuous improvement. Evaluation of processes and outcomes will also be important, but will require careful research design.

Recommendation #3:

The Exchange should seek expert advice to design an overall evaluation that would take into account all the functions and intended outcomes of the Exchange and the participating plans. The evaluation of the Exchange should address consumer utility, regulatory compliance, and business acumen, and consider meta-analysis issues such as identification of norms across states or other regions and norms across demographic groups within the plans or Exchange.

Final Vote Tally

Twenty-four work group participants endorsed the recommendation; one expressed concern; none opposed it.

Rationale

Work group participants believe that deep thought must be given to identify the essential outcomes for the Exchange and key performance indicators. They noted that enrollee satisfaction will be only one piece of an overall evaluation design.

Minority Perspectives

One work group member said the Exchange shouldn't be burdened with the cost of designing and implementing a comprehensive evaluation, which inevitably adds to the costs of the Exchange and the costs of plans within the Exchange.

Recommendation #4:

Michigan should collaborate with other states on the development and implementation of evaluation and monitoring activities for the Exchange. States similar to Michigan may be able to provide useful best practices, benchmarks, and comparative data and norms, etc.

Final Vote Tally

All work group participants endorsed the recommendation.

Rationale

Work group members believe it will be important to learn from the experience of other states, particularly the early adopter states.

Recommendation #5:

Assessment of enrollee satisfaction has to take into consideration the two-fold nature of enrollee satisfaction—that is, satisfaction with the Exchange and satisfaction with the plans operating within the Exchange.

Final Vote Tally

Work group participants approved the recommendation by acclamation.

Rationale

Work group members agreed that monitoring and evaluation of the Exchange has to include a robust consumer satisfaction component. During discussion, work group members acknowledged that health plans have measures and mechanisms for assessing enrollee satisfaction with plans and such assessments will most likely continue to evolve. Members also pointed out that enrollee expectations and perceptions will affect responses to satisfaction surveys and complicate analyses of the response data. Design of enrollee satisfaction measures and data collection mechanisms will need to take these issues into account so that distinctions can be made between enrollee satisfaction with the Exchange functions and satisfaction with the selected health plan, and satisfaction of the individual with his or her own health outcomes. Design of enrollee satisfaction measures should also consider other sources of information such as disenrollments and grievances.

In addition to the five recommendations above, the FRE work group spent time brainstorming possible measures of overall performance of the Exchange. They noted that the specific performance metrics would depend on the ultimate function of the Exchange established by the state. Their list is provided below for consideration and further development in the evaluation design:

- Percentage of population who are uninsured
- Number of people purchasing insurance through the Exchange
- Number of people purchasing insurance through the Exchange as a percentage of all people purchasing insurance in Michigan
- Age distribution of people purchasing insurance both inside and outside the Exchange
- Overall enrollment in the Exchange compared to projections
- Reasons people do not purchase insurance through the Exchange
- Disenrollments
- Number of plans that apply to participate in the Exchange and the number rejected
- Characteristics of plans included in the Exchange
- Cost savings associated with the Exchange
- Quality improvements
- Improvement in health outcomes
- Number of rate increases and the percentage of the increases
- Administrative costs of the Michigan Exchange compared to Exchanges in other states

- Overall solvency of the Exchange
- Measures of the value of the Exchange to small businesses
- Satisfaction of providers and plans with the Exchange and its implementation
- Medicaid population's satisfaction with the Exchange
- Metrics for the Exchange website, such as the number of people who start an application compared to the number who complete an application
- Metrics for the Exchange call center

Technology Workgroup

Stakeholder Work Group Final Report with Recommendations

INTRODUCTION

The Technology Workgroup met four times between February 24, 2011 and April 5, 2011 to discuss and offer recommendations related to the use of technology for an Exchange. This group had three primary tasks. The first task of the workgroup was to identify approaches for educating consumers on the existence and use of the Exchange. The second task of the workgroup was to perform a high level gap analysis between the existing State of Michigan technology infrastructure and the anticipated technology resources required for interoperability with the Exchange. Finally, the Technology Work Group identified potential sources of data for determining eligibility for the subsidies and tax credits that will be available through the Exchange.

RECOMMENDATIONS

Recommendation #1:

There should be a single person or entity with direct responsibilities for outreach, education, and enrollment. This entity should develop and test messages for both general and target audiences. When possible, existing groups and organizations should be used to help inform potential consumers about the Exchange.

Final vote tally:

Twenty-two participants endorsed the recommendation. None opposed it.

Rationale:

In the discussion preceding the vote, the work group members provided the following comments in support of the recommendation:

- The Exchange will need to build the outreach on a solid foundation by having an owner/coordination role specifically responsible for the "informing the consumer" function.
- The Exchange should leverage the many existing outreach programs available today through the Michigan Departments of Community Health and Human Services (MDCH and MDHS).
- The owner of the information and education role should recognize the many groups and community-based organizations that are willing to assist in getting the message out. These groups can also reach segments that would otherwise be unreachable. Examples of existing resources to leverage include grass roots organizations as well as brokers.
- The Exchange will need to develop a program to train and certify Navigators and brokers.
- For consumers, having a trusted messenger is very important. The content of the message should be evaluated for the targeted group. Factors such as language, disabilities, and literacy need to be considered when developing and testing the message.
- There is not a single approach that will reach all possible Exchange consumers. In order to organize an effective program, the Exchange will need to identify target consumer groups beyond the obvious ones like young, low-income, self-employed, and individuals who do not have access to computers.

Examples of organizations and tools for communication recommended by the Technology Workgroup:

- Create events covered by the media
- State of Michigan website
- Helping-Hand website
- Treasury
- Accountants and service professionals (lawyers, financial advisors, insurance agents, barber and beauty shops)
- Colleges, universities, schools
- AARP
- Non-profit groups
- Faith based organizations
- Existing State applications (Champs, Bridges)
- United Way 211
- Marketing arms of insurers participating in the Exchange (but note the fact that they cannot favor their own product in the marketing)
- Hospitals, physician groups, medical facilities and institutions
- Bingo halls and casinos
- Help lines – Medicaid, food and nutrition, my child, etc.
- Businesses and business organizations like SBAM (Small Business Association of Michigan) and chambers of commerce

Minority perspectives:

There were no minority perspectives regarding this recommendation.

Call Center/Web Portal

The work group discussed how a call center or web portal should assist people with plan enrollment. Consensus was not reached, but proposals included that a call center/web portal should exist to help with questions on the exchange, and that policy or eligibility questions should be referred to an external advocate, who would be provided with training and materials to assist the consumer.

Final vote tally:

Thirteen work group members endorsed this recommendation. Nine work group members indicated having concerns. None opposed it.

Discussion:

Those in favor of the proposal suggested that when a consumer does not feel comfortable going through the portal on their own, they should be directed to consumer advocacy groups or navigators who can assist them further. This would be facilitated by the creation of a web portal and Interactive Voice Response (IVR) call center with the ability to chat with representatives, support navigators, and direct consumers to the best source of information / assistance.

Those who had concerns with the proposal made the following comments:

- The definition of the call center function is incomplete.
- Do we want to extend the function of the call center? For example, will we need full call center functionality in addition to outreach in the community?
- Does this meet the requirements of the law?

Recommendation #2:

The Technology Workgroup was asked to identify the potential for interoperability between the Exchange and existing state systems that might be leveraged for the determination of eligibility for Medicaid and MIChild as well as plans offered in the Exchange. At its first meeting, the work group identified the following list of state systems that could potentially interoperate with the Exchange to assist with eligibility determination. The work group recommended that the following list of state systems be evaluated further at future meetings of the work group:

- Bridges
- MiBridges
- CHAMPS
- CSHCS (Children's Special Health Care System)
- Data Warehouse
- Michigan County Health Plan Association
- MIChild eligibility system
- Healthy Kids
- Plan First
- Moms
- MiHIN HIE
- Office of Finance and Insurance Regulation (OFIR)
- SOM HIE

Final vote tally:

Eighteen work group members voted in support of the proposed list as a starting point for planning purposes. Four work group members indicated having concerns with the list. None opposed it.

Rationale:

Work Group discussion focused on identifying which State of Michigan information technology resources should be further analyzed for interoperability with the Exchange. It was believed that Bridges, MiBridges, CHAMPS, and the MDCH Data Warehouse had existing data and/or functionality that could be leveraged for eligibility determination in the Exchange. MiHIN HIE, SoM HIE and OFIR have a role in interoperability for the Exchange albeit probably not for the determination of eligibility.

Minority Perspective:

Michigan County Health Plan Association, Healthy Kids, Plan First and MOMS are not State of Michigan sources of data for eligibility. Instead they are existing programs or services. The group requested the list continue to be re-evaluated in subsequent meetings.

Recommendation #3:

During the second meeting, representatives of several of the systems identified at the first meeting provided presentations on these systems from their fellow work group members. After the presentations and further discussion, the work group identified the following systems as most applicable to the Exchange:

- Bridges
- Mi-Bridges
- CHAMPS

- CHSCS
- DCH Data Warehouse
- MARS
- MIChild
- MiEnrolls
- SoM-HIE

Vote Tally:

Twenty-one members voted in favor of the final list of state systems; two had concerns.

Rationale:

Existing State of Michigan systems from the Department of Community Health, Department of Human Services, and the MiEnrolls suite provide the functionality to determine Medicaid eligibility. There is no existing data or functionality within the State of Michigan enterprise to determine eligibility for subsidized or unsubsidized individuals or small groups. In addition, there is a need to develop a single source of truth for Exchange functions beyond the determination of eligibility. Currently, there are numerous Federal systems that have not been made available for use by the Exchange, and the roles of these systems as envisioned by the **Office of the National Coordinator for Health Information Technology** (ONC) remains unclear. Information such as income, demographics, or current eligibility for other programs is currently available in a host of external systems. However, there is no single point of reference, which would make each interoperability point a composite reference with no clear hierarchy of use.

Minority perspectives:

Some participants felt the universe of systems reviewed by the workgroup did not include all possible systems. Such omissions include private insurance, MiHIN, 211, MiChild Help Line, and Medicaid Help Line. Others felt strongly that the functionality for the examined systems did not account for keeping families together in the system nor did they have adequate facilities for updating eligibility requirements.

Medicaid eligibility determination is important. The Exchange will also have to determine eligibility for tax credits and subsidies for people who are not eligible for Medicaid, and the majority of systems discussed in the work group will not be able to assist in eligibility determination for the non-Medicaid population.

Additional Data Considerations

The first three meetings of the Technology Work Group were focused on the identification and assessment of systems that would primarily assist the Exchange with the determination of eligibility for Medicaid or other public programs. During its final meeting, the work group identified and discussed additional sources of data that will be required for interoperability.

The following observations and recommendations were made by the work group regarding sources of data for eligibility determination:

1. The IRS interoperability gap regarding income information will eventually be filled because Federal stakeholders have stated that interfaces to IRS data sources for identifying adjusted gross income will be built and provided to all states implementing an Exchange.
2. The State treasury data includes—and Bridges may supply—residency status.
3. Quarterly wage reports may supply employment status.

4. Private pension income would have to be determined from hard copy; public pensions are available in the public employees' pension systems.
5. Worker's Compensation and Payroll could come from DELEG (Michigan Department of Energy, Labor and Economic Growth).
6. Pay stubs and payroll information could come from third party systems that provide proof of employment and payroll information.
7. Citizenship status could come from the Social Security Administration, Michigan Secretary of State, immigration control (US CIS), and the Michigan Department of Human Services.
8. DEERS (Defense Enrollment Eligibility Reporting System) could provide information for veteran's eligibility, filling the identified gap for Veterans Administration (VA). However, this functionality goes beyond the scope of the law.

Work group members also made the following suggestions and observations related to how information will be collected, verified, and used.

1. Interoperable systems provide both point-in-time (i.e., current) and historical information. Where possible, the Data Warehouse should be used for historical information, which will assist the Exchange in retroactively determining status and eligibility when necessary.
2. Self-reported information should be allowed. Self-reporting can be more accurate than third party data sources. And while there are many different "source of truth" sources of information, timeliness is an important factor. For example, income information is not available from the IRS until the subsequent year.
3. Because the "source of truth" varies by data type and field, a hierarchy of data sources, validation and filters will need to be implemented on the front end of the exchange. 'Data suppliers' will form a composite, hierarchical data base structure that is determined on a case by case basis. The 'source-of-truth' composite needs to be evaluated continuously going forward.
4. Some classes of data should be validated. It has not yet been determined who/what is liable if self-attestation provides a wrong or inaccurate answer. While the Exchange may not be the absolute risk bearer in terms of determining eligibility, the recommendation is that it must meet industry standards for accurate information. Since insurance carriers will rely on the information in the Exchange, ultimately the Exchange is responsible to do its part of due diligence to prevent people that are ineligible from participating in the Exchange. Medicaid has a vehicle for investigating fraud that could be leveraged on the back end to ensure accurate information.
5. There needs to be a reconciliation process for when self-reported information varies from the 'source of truth' or is changed by the applicant.
6. The Exchange is not mandated by law and so should not be responsible for coordination of benefits.
7. If a business qualifies to have its employees covered through the Exchange, its employee FTE roster, along with certain data elements (e.g., social security numbers), should be uploaded to the Exchange. The Exchange should validate the Michigan employer tax identification number, size, and whether the business is Michigan-based or not.
8. The Exchange is not responsible for business and covered employees for commercial insurance.
9. The IRS uses a different definition for "family" and "size" than the existing DHS policy uses for its medical enforcement policy. These terms will have to be reconciled.
1. Compelling out-of-state employers to comply could be a challenge.
2. The Exchange must determine a way to direct employees to the options an employer is offering.

3. Jail systems and the state court administrators' office (SCO) are an interoperability gap. The subject of coverage status during incarceration brought up three policy questions:
    - What is the life of a subsidy once it is determined that a person is eligible to receive it?
    - Is it the function of the exchange to continuously monitor eligibility?
    - How can the gap between federal and state subsidy be managed?

Regulatory and Policy Action Workgroup

Stakeholder Work Group Final Report with Recommendations

INTRODUCTION

The Regulatory and Policy Action Work Group met four times between February 25, 2011 and April 7, 2011 to discuss and recommend language for legislation to establish an Exchange in Michigan. The proposed legislation developed by the Regulatory and Policy Action Work Group was intended to reflect recommendations made by the other four work groups, which were concurrently deliberating on the governance structure, an approach to the certification of qualified health plans, transparency guidelines, and financing strategies for the Exchange.

The draft legislative language proposed by the work group resembles very closely the model legislation developed by the National Association of Insurance Commissioners (NAIC), as work group members were generally comfortable with the language developed by the NAIC and believed that it met the requirements laid out in the ACA. Work group discussion was also based on the "Additional Legislative Options to the NAIC American Health Benefit Exchange Model Act" prepared by the National Academy of Social Insurance (NASI).

The draft legislation as proposed by the Regulatory and Policy Action Work Group follows. All items on which a vote was taken are indicated as such. There are also more than a dozen drafting notes that describe, in some cases, decisions that were agreed to without a vote and, in others, items on which consensus could not be reached and discussion led to a split decision on how or whether to include certain legislative language. Items that are included in the draft Act with no indicated vote were approved by work group members by acclamation. This primarily occurred when the wording in the model legislation matched what is found in the ACA and the work group members saw no reason to change it.

Michigan Health Benefit Exchange Act

Final Report of the
Regulatory and Policy Action Work Group

April 2011

Drafting Note 1: *All items on which a vote was taken by the Regulatory and Policy Action Work Group are indicated as such. Items that are included in the draft Act with no indicated vote were approved by work group members by acclamation. This primarily occurred when the wording matched what is found in the ACA and the work group members saw no reason to change it.*

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Section 1. Title

This Act shall be known and may be cited as the *Michigan Health Benefit Exchange Act*.

~~Section 2. Purpose and Intent~~

Recommendation 1: *The Regulatory and Policy Action Work Group voted to strike this section from the draft Act.*
20 people voted in favor of striking the section; one had concerns with striking it; and two people wanted to keep the section in the Act.
Rationale: *Michigan laws do not typically have "Purpose and Intent" sections. The purpose and intent, work group members felt, should come through in the title of the Act and in the law as it is written. It was also noted that striking the section could help avoid political conflict over the language contained in the Act.*
Minority perspective: *A small minority of work group members felt that it could be a good idea to have at least some language that directly lays out the purpose of the Act.*

Section 3. Definitions

For purposes of this Act:
AAA. "Actual cost of coverage" means…

Recommendation 2: *When the work group considered Item H in Section 6 of the model legislation, they voted to add a definition for "actual cost of coverage" to Section 3. 16 members voted in favor of the recommendation and 5 indicated having concerns.*
Rationale: *Many work group members stated the importance of making consumers aware that the insurance premium they would pay does not constitute all of the costs of* care. *Thus, they believed it important to define "actual cost of coverage" in the section of the act that contains definitions.*
Minority perspective: *The 5 members who indicated having concerns with the final recommendation said that they would like to require that a statement be posted on the same screen as the calculator to inform consumers that the premium is not the only cost associated with health insurance.*

AA. "Catastrophic plan" means that term as it is defined in Section 1302 of the federal act.

Recommendation 3: *The Regulatory and Policy Action Work Group voted unanimously to point to the definition of "catastrophic plan" contained in the federal act as opposed to including a lengthy definition that, while it comes from the federal act, may at some point in the future be amended through federal rules.*

A. "Commissioner" means the Commissioner of Insurance.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

E. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(2) "Health benefit plan" does not include:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
- (b) Coverage issued as a supplement to liability insurance;
- (c) Liability insurance, including general liability insurance and automobile liability insurance;
- (d) Workers' compensation or similar insurance;
- (e) Automobile medical payment insurance;
- (f) Credit-only insurance;
- (g) Coverage for on-site medical clinics; or
- (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;
(b) Benefits for long-term care, nursing home care, home health care community-based care, or any combination thereof; or
(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:
(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
(c) Similar supplemental coverage provided to coverage under a group health plan.

F. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, a nonprofit health care corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note 2: *Although a formal vote was not taken, work group members agreed by acclamation that "nonprofit health care corporation" should be added to the definition of Health carrier.*

FF. "MIChild" means…

Drafting Note 3: *Although a formal vote was not taken, work group members agreed by acclamation that a definition for MIChild should be added to this section.*

G. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7E of this Act.

H. "Qualified employer" means a small employer that elects to make *all of* its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:
(1) Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

I. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

J. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;
(2) Resides in this State;
(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and
(4) Is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

K. "Secretary" means the Secretary of the federal Department of Health and Human Services.

L. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

M. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

(2) For purposes of this subsection:
(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;
(b) An employer and any predecessor employer shall be treated as a single employer;
(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;
(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and
(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. (1) There shall be a public instrumentality to be known as the [insert official title of the Exchange], which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency, or political subdivision of the State except as specifically provided in this Act.

(2) The [insert official title of the Exchange] shall be governed by an Executive Board consisting of 14 individuals. The Directors of the Michigan Departments of Community Health, Human

Services, and Technology, Management and Budget shall serve as voting ex-officio members of the board. The Commission of the Office of Financial and Insurance Regulation shall serve as a nonvoting ex-officio member of the board.

(3) Members of the Board other than ex-officio members shall:

a. Be appointed by the Governor with the advice and consent of the Senate.

b. Be appointed for a term of ___ years, except that the initial appointments shall be for a term of ___ years.

c. Include 10 voting members representing:

i. Small employers

ii. Labor

iii. Health care providers

iv. Health care consumers

v. Actuary

vi. Health plan benefit specialist

vii. Health economist

viii. Self-employed individuals

ix. Large employers

x. Health insurance industry

Drafting Note 4: *The Governance Work Group recommended that the governor take diversity into consideration when making Board appointments.*

(4) Board member conflicts of interest must be declared. If a member—organizationally or individually—would derive direct and specific benefit from a decision of the board, that person must recuse himself or herself from the discussion and vote on the issue.

(5) The Board shall appoint an Executive Director of the [insert official title of the Exchange], who shall appoint other staff as necessary.

Drafting Note 5: *The Governance Work Group made the following recommendation regarding the hiring practices of the Exchange:*

"The Exchange board should study existing models for hiring staff in independent public authorities (e.g., MEDC and others in Michigan) and adopt the practices that it deems best given the goals of the Exchange."

(6) In order to ensure efficient operation of the [insert official title of the Exchange], the Executive Director may seek assistance and support as may be required in the performance of its duties from appropriate state departments, agencies, and offices.

(7) The Exchange may use the Department of Technology, Management and Budget process for the procurement of goods and services. The procurement process shall be transparent. The Exchange shall consider diversity in its selection of vendors.

(8) The Board shall be subject to the Open Meetings Act and Freedom of Information Act.

Drafting Note 6: *The Regulatory and Policy Action Work Group voted to approve Section 4, Item A as drafted based on recommendations made in the Governance Work Group with the caveat that a drafting note be included to express its concerns with the the conflict of interest policy. The vote on this was as follows: 14 in favor, 1 member with concerns, and 2 opposed.*

Given the composition of the Exchange Board of Directors voted on by the Governance Work Group, Regulatory and Policy Work Group members believed that the conflict of interest policy developed by the Governance members is insufficient. One recommendation made by the Regulatory and Policy Work Group is to clarify that declaration *of conflicts of interest means "written disclosure of conflicts prior to appointment by the governor."*

Additionally, some work group members noted that term limits for board members should be considered and that the law should specify that the Exchange may transition to a non-profit entity in the future.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans;

(3) Meet the requirements of this Act and any regulations implemented under this Act; and

Recommendation 4: *The work group voted to include the language above for sub-items (1)–(3) as written, and not to include the language NASI had proposed for sub-item (4). 15 members voted in favor of this recommendation; 4 indicated having concerns; and one opposed the recommendation. Thus, the recommendation to include the sub-items above passed with no further discussion.*

(A second vote was taken to assess members interest in including sub-items (1)–(3) as well as sub-item (4) as written. 4 members voted in favor of this proposal; 10 members indicated having concerns; and 6 voted against the proposal.)

Rationale: *These votes demonstrated that there was clear support for sub-items (1)–(3), but a lack of clarity around sub-item (4). With no further discussion on sub-items (1)–(3), they were considered approved. The work group then discussed sub-item (4) to arrive at the recommendation described below.*

(4) Coordinate and consult with the state agencies that determine eligibility and enrollment for Titles XIX and XXI of the Social Security Act.

Recommendation 5: *The work group voted to include the language shown above for item (4) as an alternative to what had been proposed in the NASI model legislation. 19 members voted in favor of the above language; 3 indicated having concerns; and 2 opposed the inclusion of the language.*
Rationale: *The primary reason for including the language in item (4) is to encourage coordination and cooperation among the Exchange, Medicaid, and MIChild. Work group members believed it was worth making a statement that coordination is expected, even though the final language here is not as strong in its direction as the NASI-proposed language.*

Minority Perspective: *A minority of work group members felt that this language is unnecessary, suggesting that language in the federal law regarding coordination among these entities is sufficient to encourage action at the state level.*

C. The Exchange may contract with or enter into a memorandum of understanding with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of state Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

D. The Exchange shall enter into information-sharing agreements with federal and State agencies and other State Exchanges as needed to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 6. Duties of Exchange

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance, utilizing staff that is trained to provide assistance in a culturally and linguistically appropriate manner.

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

Drafting Note 7: *The Regulatory and Policy Work Group discussed whether to include another Item in Section 6 to require the Exchange to provide information concerning eligibility for Medicare or other federal programs. The group was split on this idea: 9 voted in favor, 2 had concerns, and 6 were opposed. They agreed, however, that a drafting note should be included to encourage the drafters of the final legislation to consider this provision. Those in favor of including the provision in the law noted that (1) having people covered by Medicare rather than Medicaid or another state-subsidized program would be financially advantageous to the state and (2) it is in keeping with the idea of the Exchange assisting consumers in making informed decisions about their health care coverage and being aware of the various options. Those opposed to including the provision indicated concern that this would result in a requirement for the Exchange to determine eligibility rather than just provide information.*

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act.

Recommendation 6: *The work group voted to keep the language above for Item H, but to delete a second sentence that had been added by NASI that required the calculator to provide consumers with information on out-of-pocket costs for in-network and out-of-network services. The vote by the work group also included a recommendation to add a definition for "actual cost of coverage" to Section 3 of the Act. 16 members voted in favor of the recommendation and 5 indicated having concerns.*

Rationale: *Work group members agreed that the first sentence of the draft legislation met with the requirements of the federal act. They believed that the second sentence that had been added by NASI would be very difficult, if not impossible, to implement given variations among plans. Many work group members, however, stated the importance of making consumers aware that the insurance premium they would pay does not constitute all of the costs of* care*. Thus, they believed it important to define "actual cost of coverage" in the section of the act that contains definitions.*

Minority perspective: *The 5 members who indicated having concerns with the final recommendation said that they would like to require that a statement be posted on the same screen as the calculator to inform consumers that the premium is not the only cost associated with health insurance.*

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

Recommendation 7: *The work group voted to include Item I as it was written above by NAIC and not to use the alternative developed by NASI. 16 members voted in favor and 1 indicated having concerns.*

Rationale: *There was very little discussion about the Item as written above since members recognized this as the language that is in the ACA. The primary reason for voting against including the alternative language, which required the Exchange to provide premium aggregation and other related services to minimize administrative burdens for employers, was that it might not be in keeping with the recommendation of the Business Operations Work Group that the Exchange would serve as a market facilitator.*

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:
   (1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
   (2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:
   (1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;
   (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:
      (a) The employer did not provide minimum essential coverage; or
      (b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
   (3) The name and taxpayer identification number of:
      (a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
      (b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection (K)(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, standards developed by the Secretary and the selection criteria in subparagraph (1).
   (1) Award grants to enable Navigators to:
      a. Conduct public education activities to raise awareness of the availability of qualified health plans;

b. Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost sharing reductions under section 1402 of the Federal Act;
c. Facilitate enrollment in qualified health plans;
d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage;
e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange; and
f. Provide information and tools to Exchange participants for the assessment of plans and procedures for transitioning among Medicaid, CHIP, and Exchange plans and other coverage.

Recommendation 8: *Add to the list of navigator duties the provision of information and tools to assist Exchange participants in the assessment of plans and understanding procedures for transitioning among Medicaid, CHIP, and Exchange plans (item f). 17 members voted in favor of the proposed language; 5 members indicated having concerns; and 2 voted against the proposed language.*

Rationale: *The language approved by the work group members for sub-item f is a modification of language proposed by NASI in its model legislation, which said that Navigators would "counsel" Exchange participants about the selection of plans and transition procedures. Work group members were generally uncomfortable with allowing Navigators to counsel participants given lack of clarity around the qualifications of Navigators to perform such a task. They noted it is unlikely that Navigators would achieve the same level of expertise in this area that is currently required of insurance agents and brokers. Members generally agreed, however, that it would be important to help those Exchange participants who are likely to move among Medicaid, CHIP, and Exchange plans understand their options.*

Drafting Note 8: *A slim majority of work group members voted to delete Section 6N, sub-item (2), a NASI-added sub-item that would require the Exchange to ensure that there are a sufficient number of Navigators to serve disadvantaged and hard-to-reach populations. 15 members voted to delete the item; 6 members indicated having concerns with the item; and 5 members voted in favor of keeping the item. Given that a majority voted to delete it and more members indicated having concerns than wanting to keep it, no further votes were taken on the item.*

Discussion: *As work group members deliberated on this item, the primary points made in favor of deleting the item were that (1) it is difficult to define "sufficient" and (2) it may be too onerous a requirement for the Exchange. The minority in favor of keeping the section believe it is important to consider the needs of disadvantaged populations in facilitating access to the Exchange.*

Drafting Note 9: *A majority of work group members voted to delete Section 6N, sub-item (3), a NASI-added sub-item that would allow the state to require the certification of Navigators. 17 members voted to delete the item; 7 members indicated having concerns with the item; and 2 members voted in favor of keeping the item. While this did not quite meet the two-thirds threshold, a majority voted to delete it and more members indicated having concerns than wanting to keep it, so no further votes were taken on the item.*

Discussion: *As work group members deliberated on this item, the primary points made in favor of deleting the item were that (1) the ACA already allows for this so it is unnecessary to include in the Michigan Act; and (2) "allowing" it may lead to "requiring" it, which members generally did not support. Those in favor of keeping the section emphasized that the language says the state* may *require certification and that the language is consistent with the federal act.*

O. Consider the rate of premium growth within the Exchange and outside the Exchange, in developing recommendations on whether to continue limiting qualified employer status to small employers;

Recommendation 9: *The work group voted overwhelmingly in favor of making a slight revision to the language that had been proposed by the NAIC in its model legislation. The language above reflects a change from beginning the Item with "Review" to "Consider" and adjusting the rest of the sentence to fit with that formulation of the phrase. 23 work group members voted in favor of the revised language; 1 member indicated having concerns.*

Rationale: *Work group members wanted to emphasize that this information should be considered as one of several factors in the decision regarding whether to allow larger employers to participate in the Exchange after 2016.*

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:
   (1) Educated health care consumers who are enrollees in qualified health plans;
   (2) Individuals and entities with experience in facilitating enrollment in qualified health plans;
   (3) Representatives of small businesses and self-employed individuals;
   (4) Health care providers
   (5) Insurance carriers
   (6) The [insert name of State Medicaid office];
   (7) The Office of Financial and Insurance Regulation; and
   (8) Advocates for enrolling hard to reach populations

Recommendation 10: *Work group members voted in favor of adding "Health care providers," "Insurance carriers," and "OFIR" to the list of relevant stakeholders proposed by NAIC in its model legislation. 23 members voted in favor of the additions; 1 member opposed them.*

Rationale: *These additions were supported by a large majority of work group members given the relevance of these stakeholders to the various sections of the Act and the Exchange.*

R. Meet the following financial integrity requirements:
   (1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:
    (a) Investigate the affairs of the Exchange;
    (b) Examine the properties and records of the Exchange; and
    (c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.

Recommendation 11: *The work group voted unanimously in favor of adding language to Item R to specify that the Exchange is subject to oversight by the OFIR Commissioner and adding to the Insurance Code giving this authority to the commissioner. They leave the responsibility of adding the language in both places to the drafters of the final legislation.*

Rationale: *Work group members noted that state-level oversight for meeting financial requirements would probably be best suited for the OFIR Commissioner.*

R2. The Exchange shall work jointly with the state Medicaid and CHIP agencies to develop and administer transition procedures that address the needs of individuals and families who experience a change in income that results in a change in the source of coverage.

Recommendation 12: *The work group voted in favor of using the above language from the NASI-added sub-item R2. 16 members voted in favor of the language above; 7 indicated having concerns; and 1 voted against the language.*

Rationale: *The work group learned from the state subject matter experts that very little exists in the way of formal procedures to assist people with transitioning on and off Medicaid or to other sources of coverage. Work group members generally agreed that having policies that could assist people who are likely to move between Medicaid and Exchange plans would be positive. The NASI language for R2 included additional language that requires the development of policies that, to the extent possible, provide for the coordination of payments to MMCOs and Exchange plans. Work group members did not want to include this because they believed it would be nearly impossible for the Exchange to do.*

Minority perspectives: *Members who had concerns with or opposed the recommendation wondered how often eligibility for Medicaid and/or Exchange plans will be redetermined, which could affect the ease with which this recommendation is administered. Others believe it is unnecessary to include this language in the state law, since it is addressed in the ACA.*

Recommendation 13: *Work group members voted overwhelmingly against including Section 6 Item R3, a NASI-added item that requires the Exchange to work with the state Medicaid and CHIP agencies to develop policies that encourage the development and participation of plans that cam serve Medicaid, CHIP, and Exchange enrollees. 20 members voted against including the item; 3 members expressed concern with the item; 2 members voted in favor of keeping the item.*

Rationale: *Work group members were concerned with the language for three primary reasons. First, many said, plans should be able to continue to specialize in their respective markets; there are distinct differences between Medicaid and commercial plans; plans should not be forced to try to compete in both*

markets. Second, while the language says the development of these plans would be "encouraged," many work group members believe that will lead to the implementation of incentives and penalties that essentially make the development of these plans a requirement. Third, members believe that the market will address the need to have plans that operate in both markets; it is unnecessary to legislate this.
Minority perspective: *A few members believe that encouraging the development of these plans is benign, and that it is worth promoting the development of these plans to ensure continuity between different types of coverage.*

Recommendation 14: *Work group members voted overwhelmingly against including Section 6 Item R4, a NASI-added item that required additional coordination between the Exchange and Medicaid and CHIP. The Item had three sub-parts, each of which was voted down by a large majority of members.*
R4(1): *22 members voted against including sub-item (1); 1 expressed concern; 1 voted to keep it*
R4(2): *22 members voted against including sub-item (2); 2 voted to keep it*
R4(3): *19 members voted against including sub-item (3); 5 voted to keep it*

Rationale: *While the items each address a slightly different aspect of coordination among the three entities, work group members' comments on each reflected a similar strain of thought. They generally believe that the market will address the need for coordination, and that, the issue of coordination is covered in the ACA and does not need to be further addressed in Michigan statute.*

Minority perspective: *Members who had concerns with or opposed omitting these items generally liked the idea of encouraging this level of coordination in the state law versus leaving it to the market or what is written in the ACA.*

Recommendation 15: *The work group members voted against including Section 6 Item R5, a NASI-added item which would either require or allow the Exchange, Medicaid, and CHIP to exchange data on health plan performance, and instead making the following statement: "The legislature should consider the need to instruct Medicaid and MIChild to share the data that they currently collect on health plan performance with the Exchange." The work group does not expect that language to be part of the law, but to be shared with the legislature, which could decide if a new Medicaid policy is necessary to require the sharing of this data. 17 members supported this recommendation; 7 expressed concern; none opposed it.*

Rationale: *Work group members generally felt that there is not any information on health plan performance that the Exchange would need to share with Medicaid or CHIP, but that there is very likely to be information that Medicaid and CHIP would need to share with the Exchange for reporting purposes. They believe that this Act is not the appropriate place for placing a requirement on Medicaid or CHIP. That should be handled as a change to Medicaid policy.*

Minority perspective: *Members who expressed concern with the statement developed by the work group noted that information on Medicaid health plan performance is widely disseminated; the sharing of this information, they believe, does not need to be legislated or put into a policy.*

Section 7. Health Benefit Plan Certification

A. The Exchange shall certify a health benefit plan as a qualified health plan if:

Recommendation 16: *Work group members voted overwhelmingly in favor of replacing the word "may," which was in the NAIC model legislation, with the word "shall" in the above lead-in to the criteria for health plan certification. 23 members voted for the change; one opposed the change.*

Rationale: *The Business Operations Work Group voted in favor of making the Exchange a market facilitator, not a selective contractor or active purchaser. The members of this work group were concerned, then, that the use of the word "may" would give the Exchange latitude to not allow certain carriers to offer plans in the Exchange. As was voted on by the Business Operations Work Group, the language should ensure that any carrier that is able to meet the requirements of the ACA is allowed to provide its plans in the Exchange.*

Recommendation 17: *The members considered the fact that the Business Operations Work Group voted to allow the Exchange to limit the number of plans offered by a single carrier. They recommended that the following statement be included in some form in Section 7 to address this:*
"If the Exchange finds an unmanageable number of plans offered in a single benefit level, the Exchange may establish a reasonable limit for the number of plans offered per carrier. The criteria for establishing a reasonable limit shall be non-discriminatory and equally applied in a manner that assures a level playing field between or among health carriers participating in the Exchange." 22 members voted in favor of adding this statement; 1 member expressed concern.
The members suggested that this concept might fit best either as a fourth sub-part to Item B or as a sub-part to Item D.

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E, if:
   (a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and
   (b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:
   (a) Is licensed and in good standing to offer health insurance coverage in this State;
   (b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;
   (c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

Recommendation 18: *Work group members voted overwhelmingly in favor of including sub-items (1)–(6) as drafted by the NAIC; they did not include the alternative language offered by NASI, which would allow the Exchange to selectively contract with health plans. 23 members voted in favor of including the language as written above; one member expressed concern.*

Rationale: *The language was approved because it lays out the criteria for plan certification as specified in the federal act.*

(7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Recommendation 19: *Work group members voted overwhelmingly in favor of including sub-item (7) as written by NAIC. 23 members voted in favor of the language; one expressed concern.*

Rationale: *Work group members recognized that this language provides some flexibility to the Exchange as it makes decisions regarding the certification of health plans as qualified health plans, which they believe emphasizes the need to have "shall" at the beginning of Item A. It also supports recommendation made by the Business Operations Work Group to allow the Exchange to limit the number of plans offered by a single carrier, if necessary.*

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;
(iii) Data on enrollment;
(iv) Data on disenrollment;
(v) Data on the number of claims that are denied;
(vi) Data on rating practices;
(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
(viii) Information on enrollee and participant rights under title I of the Federal Act; and
(ix) Other information as determined appropriate by the Secretary; and

Drafting Note 10: *The work group approved by acclamation the inclusion of the Item 2(a) and all of its sub-parts as written above. They then considered the information that the Finance, Reporting, and Evaluation Work Group recommended that the Exchange should make available to assist consumers with their purchase decisions. These are as follows: exclusions from coverage; availability of providers, including whether they are accepting new patients and the language(s) spoken by the provider; coverage, costs, and procedures for out-of-area care; and participation of plan providers in health information exchanges. The work group suggests that the drafters of the final legislation consider whether qualified health plans should be required to report the information recommended by the Finance, Reporting, and Evaluation Work Group. They note that these drafters of the legislation should evaluate whether (1) the information is feasible to require, (2) the information is already covered elsewhere in the Act or through another means, and (3) requiring the information will maintain an even playing field among carriers on and off the Exchange.*

Discussion: *Work group members noted that whether a provider is accepting new patients is important to know, but others stated that this is difficult for carriers to keep track of and a requirement to report this may place an undue burden on health carriers. They suggested that the Exchange should direct consumers to check with plan providers to see if they are accepting new patients and to find out which languages are spoken in the practice.*

Other members were concerned primarily with the information regarding coverage and costs for out-of-area care, since it could have a bearing on consumers with children who are away for college and those who may travel frequently for work. Work group members noted that carriers generally post this information on their websites. Other members wondered if information from carriers web sites can be incorporated into the Exchange website, emphasizing the intent for the Exchange to be a "one stop shop" for plan selection.

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

Drafting Note 11: *The work group briefly discussed sub-items (4) and (5), which had been added by NASI, and indicated by acclamation that they opposed them. Sub-item (4) required plans to promptly notify affected individuals of price and benefit changes or other changes in circumstance that could*

materially impact enrollment or coverage. The group said that it was unclear what was meant by "materially impact" and they generally did not want to add more requirements for health plans in the Exchange. Sub-item (5) required the provision of timely updates regarding the plan's provider network, which work group members deemed covered in their discussion of sub-item (2) above.

D. The Exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.

E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation; and

(4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Drafting Note 12: *The following language was proposed as an alternative to sub-item (4) above: "A health carrier alone or in conjunction with a dental carrier may offer a comprehensive plan through the Exchange in which the dental benefits are provided, provided that the plans are priced separately and are also made available for purchase separately at the same price." Work group members were undecided about whether to accept this language, as evidenced by a vote where 3 members supported the language, 13 members indicated having concerns, and 1 member opposed it.*

The proposed language is intended to require that dental benefits offered either as part of a qualified health plan or separately by a qualified dental plan be priced and purchased separately from the health benefits. This would ensure that stand-alone dental plans are given due consideration by prospective enrollees and that these dental benefits could be compared side-by-side with those offered by health plans.

Discussion: *Work group members generally agreed with the premise that it could be helpful to select dental benefits separately from health benefits, but they needed more clarity about the language offered and how this would work in practice. A concern was raised about where "accidental dental" benefits would fit into this structure since these are almost always covered by health plans. It was clarified that the dental benefits that would be priced and purchased separately would be the pediatric dental benefits that the ACA requires to be included in the essential benefit package.*

Drafting Note 13: *Further discussion on sub-item (4)—both as written by NAIC and in the newly proposed language—revealed concern with the phrase "at the same price." Some work group members*

were concerned that this meant that a reduced price could not be offered to prospective enrollees for purchasing a "bundled" package of health and dental benefits.

Drafting Note 14: *The work group agreed without a vote to strike Item E2, which had been added by NASI to indicate with whom oversight of certified health plans would lie. The language offered three alternatives: (1) oversight lies primarily with the Commissioner of Insurance, (2) oversight is fairly equally divided between the Exchange and the Commissioner, or (3) oversight is the primary responsibility of the Exchange. Work group members noted that oversight is already specified clearly within the Act as the primary responsibility of the Exchange. They also note that it will remain the responsibility of the Commissioner of OFIR to ensure that all health carriers in the state meet requirements related to licensure and solvency.*

Section 8. Funding; Publication of Costs

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

Recommendation 20: *The work group voted unanimously to include Item A as written along with the drafting note below that lays out the recommendations made in the Finance, Reporting, and Evaluation Work Group regarding options for financing the Exchange.*

Drafting Note 15: *During its final meeting, the Financing, Reporting, and Evaluation Work Group discussed and recommended several strategies for financing the Exchange. The work group recommended sources for startup financing:*

1. If Medicaid is included in the Exchange , state and federal Medicaid funds should be used to pay Medicaid's fair share of startup costs, including the cost of establishing a Medicaid eligibility determination system if that function is included in the Exchange.
2. The state should seek the maximum amount of federal funds available to support startup costs of the Exchange.
3. The state should seek funding from foundations, including private, community, and national foundations, to support startup costs of the Exchange.
4. There should be a fee for carriers to participate in the Exchange beginning at startup. This funding mechanism should be only one piece of the financing strategy for startup of the Exchange. The assumption is that the carrier will cover the fee out of what they typically would spend for distribution outside of the Exchange. The balancing act for the Exchange is to determine how much the Exchange can charge carriers without setting the fee at a level where the carriers choose not to participate or the cost passed on to the consumer becomes a burden.
5. Since all of Michigan benefits from the creation of the Exchange, state revenue options that spread the cost over the widest base possible by ability to pay should be one piece of the financing strategy at startup.

The Finance, Reporting, and Evaluation Work Group made the following recommendations for financing the ongoing operations of the Exchange:

1. If Medicaid is included in the Exchange, the state should seek to maximize federal matching funds for Medicaid costs associated with the ongoing operation of the Exchange.
2. Once the Exchange is operational, carriers should be required to pay a fee to participate in the Exchange. This funding mechanism should be one piece of the financing strategy for ongoing operation of the Exchange. During the operational phase of the Exchange, the Exchange will still be challenged to set the participation fee at a level that does not discourage carriers from participating and does not result in a cost burden for the consumer.

3. After it is well-established, the Exchange should seek entrepreneurial opportunities that are related to its mission and do not present conflicts of interest.
4. State revenue options that spread Exchange costs over the widest base possible by ability to pay should be one piece of the financing strategy to support the ongoing operation of the Exchange.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, the administrative costs of the Exchange, and its audited financial statements on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Recommendation 21: *The work group voted unanimously to add "audited financial statements" to the list of things the Exchange would be required to publish on its web site.*

Rationale: *The group came to its recommendation as it discussed the possibility of using the alternative language offered by NASI, which required the Exchange to disclose financial expenditures above a certain dollar amount, any cash reserves at the end of the fiscal year, and estimates of its financial operations of an unspecified time horizon. Many in the work group agreed that the alternative language would make the Exchange more transparent and give consumers a fuller picture of its financial state. Ultimately, they agreed that requiring the Exchange to post audited financial statements would meet their desire for greater transparency.*

Section 9. Regulations
The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

Drafting Note 16: *The work group discussed whether the Exchange as a quasi-public entity would even be able to promulgate regulations and concluded that it could not. They suggested that either OFIR or MDCH—expressing no clear preference for either—be named as the rulemaking authority for implementation of the provisions of this Act. They felt it was important to name an agency for the promulgation of regulations for the Act; but they also noted that it was important to* allow, *not require, the promulgation of regulations.*

Section 10. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this State. Except as expressly provided to the contrary in this Act, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Section 11. Effective Date

This Act shall be effective [insert date].

Drafting Note 16: *The work group did not offer an "effective date" for the proposed legislation, but noted that the Exchange must be "testable" by January 1, 2013 or the federal government can develop an Exchange for the state.*